Integrative Therapeutic Family Services/ Mobile Crisis Stabilization Services Referral Form

Child's Name:	DOB:/_	/	Age:	Sex:
MA# S	SS#	_	_	
This child is currently residing (<i>Check One</i>): □ With be □ Foster Care □ Shelter Care □ Group Home	iological parent(s	s) 🗆 Wit	h another fami	ly member
Current caregiver of child:	Phone	:		
Address:				
Referral Agency: Agency Contact	Person:			
Phone: () Email Add	dress:			
Who has custody of the child?:	Phone: _			
Who is the legal guardian of the child?:		Relatio	nship to Child:	
Who can sign releases of information for this child? Phone: Email Addres	s:			-
Has the parent's parental rights been terminated? What is the present Permanency Plan for this youth?				
Education:				
School Name:Conta	ct:		Phone:	
Currently Enrolled: Yes No Current School Gr	ade:			
Current Medical Information:				
Name of Somatic Physician:	Phone:			
Is the child receiving mental health services? Yes	No			
Name of psychiatrist:	Phone #:			_
Name of therapist:	Phone #:			
Last Visit: Next scheduled ap What brought this child/family to the attention of DSS	ppointment: ?:			
*Individual Authorization Releases are attached. Please complete the highlighted sections, obtain signat Blank Individual Authorization Releases provided l	<mark>below.</mark> Please co	mplete one	for each service	
signed documents with completed referral. A blank release Child's therapist Child's Primary Care Physician Board of Education Child's Lawyer All additional programs child may be working with (expectation)	Child's psychologoper Department of Mental Health Foster Parents	iatrist f Social Ser g System's (if living v	vices Office vith)	we may not have included:
	- · · · · ·		•	IHSO (CSA) use only:
			ITFS:	
			MCSS	5:

${\bf INDIVIDUAL'S~AUTHORIZATION} \\ {\bf \underline{Purpose}} : This form is used to confirm the direction of an individual to authorize DHMH to request, to use, or to disclose the$

individual's health information. Please type or print neatly; we are not able	to process incomplete or illegil	ble forms.	
☐ Check if this authorization is for psycho	therapy notes. If this authoriza	tion is for psychotherapy notes, DHMH will not use it	
as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted.			
Section A: Individual's Health Information		sure.	
Last Name:	First Name:	 MI:	
Street Address:			
City:	State: _	Zip:	
Phone: (home) (work			
authorizing us to use and/or disclose. To sh		description of the health information you are	
.The purpose of the disclosure (optional): C			
Who is authorized to Receive/Disclose and	Use your health information:		
DHMH PROGRAM NAME(S) : MHSO (CS	SA)		
ADDRESS: P.O. Box 1745 Cumberland, MD	21502		
TELEPHONE NUMBER : (301) 759-5070			
Who is authorized to Receive/Disclose and	Use your health information:		
NAME(S) Garrett County Department of So	ocial Services ADDRESS	12578 Garrett Highway Oakland MD 21550	
TELEPHONE NUMBER: _301-533-3000			
If the information which the program has inclu	udes records or information from	another entity, I do or _X do not wish to have	
that information released under this authorizat		DI ETED DIMINI GANNOT A CCEPT THIC	
FORM.)	HIS SECTION IS NOT COM	PLETED, DHMH CANNOT ACCEPT THIS	
Expiration: This authorization will exp	pire (complete one):		
On//On occurrence of the following ever	nt (which must relate to the indiv	vidual or to the	
Right to Revoke: I understand that I may re-	voke this authorization at any tin	ne by giving written notice of my revocation to DHMH.	
In order to obtain a revocation form to revoke	this authorization, I understand t	that I may contact MHSO (CSA). I understand that	
revocation of this authorization will not affect any action that DHMH or others named or unnamed took in reliance on this authorization before DHMH received my written notice of revocation.			
·			
Section D: Signature To the Individual – Please read the following	าฐ.		
I authorize the use and/or disclosure of my hea	alth information as described in S	Section B above. I understand this authorization is	
		ve and/or use my health information are not subject to e the health information, and it may no longer be	
		o read and consider the contents of this authorization,	
and I confirm that the contents are consistent	with my intent.		
Signature:	Date:		
	uest, please attach a copy of any	document granting legal authority and complete the	
following: Personal Representative's Name:			
Relationship to Individual:			

Purpose: This form is used to confirm the direction of an individual to authorize DHMH to request, to use, or to disclose the

individual's health information.				
Please type or print neatly; we are not able to process incomplete or illegible forms. Check if this authorization is for psychotherapy notes. If this authorization is for psychotherapy notes, DHMH will not use it				
as an authorization for any other type of	f health information. If the indivi			
information as well, an additional form		D. 1		
Section A: Individual's Health Inform	nation authorized for Use and	<u>Disclosure.</u>		
Last Name:	First Name:	MI:		
Street Address:			_	
City:	State: _	Zip: _	_	
Phone: (home)	(work)	DOB:	_	
Section B: The use and/or Disclosure			th information you are	
authorizing us to use and/or disclose. The purpose of the disclosure (option)				
Who is authorized to Receive/Disclose	e and Use your health informat	tion:		
DHMH PROGRAM NAME(S) : MHS				
ADDRESS: P.O. Box 1745 Cumberlan	<u>d, MD 21502</u>			
TELEPHONE NUMBER : (301) 759-5	5070			
Who is authorized to Receive/Disclose	e and Use your health informat	tion:		
NAME(S) Garrett County Board of Ed	aucationADDRESS_40	South Second Street, Oakland	MD 21550	
TELEPHONE NUMBER: _301-334-8	3900			
If the information which the program has includes records or information from another entity, I do orX_ do not wish to have				
that information released under this auth Section C: Expiration and revocation		COMPLETED DHMH CA	NNOT ACCEPT THIS	
FORM.)	.(IF THIS SECTION IS NOT	COM LETED; DIMIT CA	MINOT ACCELT THIS	
	will expire (complete one):			
On/				
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Section D: Signature				
To the Individual – Please read the following. Leathering the control of the least the second strip and the secon				
I authorize the use and/or disclosure of my health information as described in Section B above. I understand this authorization is Voluntary. I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to				
the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be				
protected by the health information priv and I confirm that the contents are consi		inity to read and consider the	contents of this authorization,	
Signature:	Date: _			
If a personal representative is making th	nis request, please attach a copy o	of any document granting lega	al authority and complete the	
following:				
Personal Representative's Name:				

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Relationship to Individual:

<u>Purpose</u>: This form is used to confirm the direction of an individual to authorize DHMH to request, to use, or to disclose the individual's health information.

Please type or print neatly; we are not able to process incomplete or illegible forms. Check if this authorization is for psychotherapy notes. If this authorization is for psychotherapy notes, DHMH will not use it as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted. Section A: Individual's Health Information authorized for Use and Disclosure. Last Name: ___ MI:____ Street Address: _____ State: _ Zip: _ _ City: Phone: (home) (work) DOB:
Section B: The use and/or Disclosure being authorized provide a detailed description of the health information you are authorizing us to use and/or disclose. To share, exchange, obtain, disclose information. .The purpose of the disclosure (optional): Continuation and continuity of care Who is authorized to Receive/Disclose and Use your health information: **DHMH PROGRAM NAME(S)**: MHSO (CSA) ADDRESS: P.O. Box 1745 Cumberland, MD 21502 **TELEPHONE NUMBER**: (301) 759-5070 Who is authorized to Receive/Disclose and Use your health information: NAME(S) Pressley Ridge ______ADDRESS 8000 Thayer Center Oakland MD 21550 **TELEPHONE NUMBER**:301-533-3274 If the information which the program has includes records or information from another entity, I ___ do or _X___ do not wish to have that information released under this authorization. Section C: Expiration and revocation. (IF THIS SECTION IS NOT COMPLETED, DHMH CANNOT ACCEPT THIS FORM.) Expiration: This authorization will expire (complete one): On occurrence of the following event (which must relate to the individual or to the Purpose of the use and/or disclosure being authorized): **Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to DHMH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact MHSO (CSA). I understand that revocation of this authorization will not affect any action that DHMH or others named or unnamed took in reliance on this authorization before DHMH received my written notice of revocation. **Section D: Signature** To the Individual – Please read the following. I authorize the use and/or disclosure of my health information as described in Section B above. I understand this authorization is Voluntary. I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent. Signature: _____ Date: _____ If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following:

INDIVIDUAL'S AUTHORIZATION Purpose: This form is used to confirm the direction of an individual to authorize DHMH to request, to use, or to disclose the

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as an authorization for any other type of		lividual seeks to authorize the	e use and disclosure of other health	
information as well, an additional form in Section A: Individual's Health Inform		nd Disclosure		
Section 71. Individual 9 Hearth Inform	iation authorized for Osc ar	iu Disclosure.		
Last Name:	First Name:		MI:	
Street Address:	<u></u>			
City:	State: _	Zip: _		
Phone: (home)	(work)	DOB:		
Section B: The use and/or Disclosure authorizing us to use and/or disclose.			nealth information you are	
.The purpose of the disclosure (option				
Who is authorized to Receive/Disclose	e and Use your health inform	nation:		
DHMH PROGRAM NAME(S): MHS ADDRESS: P.O. Box 1745 Cumberland				
TELEPHONE NUMBER : (301) 759-5	5070			
Who is authorized to Receive/Disclose	e and Use your health inform	nation:		
NAME(S) Parole and Probation _ADI	ORESS 221 S 3rd Street, #A,	Oakland MD 21550		
TELEPHONE NUMBER: 301-334-81	13_			
If the information which the program has includes records or information from another entity, I do or _X do not wish to have that information released under this authorization. Section C: Expiration and revocation. (IF THIS SECTION IS NOT COMPLETED, DHMH CANNOT ACCEPT THIS				
FORM.) Expiration: This authorization w	vill expire (complete one):			
On/	viii expire (complete one).			
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Signature:	Date	:		
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(LAWYER) INDIVIDUAL'S AUTHORIZATION

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Last Name:	First Name:	MI:		
Street Address:		_ _		
City:	State: _	Zip:		
authorizing us to use and/or disc	(work) sure being authorized provide a de lose. To share, exchange, obtain, dis ptional): Continuation and continuit			
Who is authorized to Receive/Dis	sclose and Use your health informa	tion:		
DHMH PROGRAM NAME(S): ADDRESS: P.O. Box 1745 Cumb				
TELEPHONE NUMBER: (301)	<u>759-5070</u>			
Who is authorized to Receive/Dis	sclose and Use your health informa	ntion:		
NAME(S) Salem Children's Trus	ADDRESS 605 Salem Drive, Fr	costburg MD 21532		
TELEPHONE NUMBER: 301-68	<u>39-8176</u>			
If the information which the program has includes records or information from another entity, I do or _X do not wish to have that information released under this authorization. Section C: Expiration and revocation. (IF THIS SECTION IS NOT COMPLETED, DHMH CANNOT ACCEPT THIS				
	ion will expire (complete one):			
	lowing event (which must relate to the disclosure being authorized):	he individual or to the		
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Voluntary. I understand that if the the federal or state health information protected by the health information and I confirm that the contents are	e of my health information as describersons or organizations I authorize to on privacy laws, they might further a privacy laws. I have had full opport consistent with my intent.	bed in Section B above. I understand this authorization is to receive and/or use my health information are not subject to disclose the health information, and it may no longer be tunity to read and consider the contents of this authorization,		
Signature:	Date: _			
following:	ng this request, please attach a copy	of any document granting legal authority and complete the		

individual's health information. Please type or print neatly; we a	re not able to process incomplete or ille	gible forms.	
as an authorization for any other tinformation as well, an additional	ype of health information. If the individual	zation is for psychotherapy notes, DHMH will not use it I seeks to authorize the use and disclosure of other health closure.	
Last Name:	First Name:	MI:	
Street Address:			
City:	State: _	Zip:	
authorizing us to use and/or disc	(work) osure being authorized provide a detaile close. To share, exchange, obtain, disclose optional): Continuation and continuity of o		
Who is authorized to Receive/Di	sclose and Use your health information:	<u>L</u>	
DHMH PROGRAM NAME(S): ADDRESS: P.O. Box 1745 Cumb			
TELEPHONE NUMBER: (301)	759-5070		
Who is authorized to Receive/Di	sclose and Use your health information:	<u> </u>	
NAME(S)	ADDRESS		
TELEPHONE NUMBER:			
that information released under the Section C: Expiration and revoc	is authorization.	om another entity, I do orX_ do not wish to have MPLETED, DHMH CANNOT ACCEPT THIS	
FORM.) Expiration: This authoriza	tion will expire (complete one):		
	llowing event (which must relate to the incordisclosure being authorized):	dividual or to the	
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Signature:			
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Last Name:	First Name:	MI:		
Street Address:				
City:	State: _	Zip: _		
Phone: (home) Section B: The use and/or Disclosure being authorizing us to use and/or disclose. To short The purpose of the disclosure (optional):	are, exchange, obtain, disclose in	nformation.	ormation you are	
Who is authorized to Receive/Disclose and	Use your health information:			
DHMH PROGRAM NAME(S) : MHSO (CS ADDRESS: P.O. Box 1745 Cumberland, MD				
TELEPHONE NUMBER : (301) 759-5070				
Who is authorized to Receive/Disclose and	Use your health information:			
NAME(S)	ADDRESS			
TELEPHONE NUMBER:				
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Signature:	Date:			
If a personal representative is making this req following: Personal Representative's Name: Relationship to Individual:			ority and complete the	

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Check if this authorization is for psychotherapy notes. If this authorization is for psychotherapy notes, DHMH will not use it as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted. Section A: Individual's Health Information authorized for Use and Disclosure.			
Last Name:	First Name:	MI:	
Street Address:			
City:	State: _	Zip:	
authorizing us to use and/or discle	(work) ure being authorized provide a det ose. To share, exchange, obtain, disc otional): Continuation and continuity		
Who is authorized to Receive/Disc	close and Use your health informat	ion:	
DHMH PROGRAM NAME(S): MADDRESS: P.O. Box 1745 Cumber			
TELEPHONE NUMBER: (301) 7	<u>59-5070</u>		
Who is authorized to Receive/Disc	close and Use your health informat	ion:	
NAME(S)	ADDRESS		
TELEPHONE NUMBER:			
that information released under this Section C: Expiration and revoca	authorization.	n from another entity, I do or _X do not wish to have COMPLETED, DHMH CANNOT ACCEPT THIS	
	on will expire (complete one):		
	owing event (which must relate to the disclosure being authorized):	e individual or to the	
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Voluntary. I understand that if the p the federal or state health information	of my health information as describ ersons or organizations I authorize to on privacy laws, they might further d privacy laws. I have had full opportu	ed in Section B above. I understand this authorization is a receive and/or use my health information are not subject to isclose the health information, and it may no longer be unity to read and consider the contents of this authorization,	
Signature:	Date:		
following:	ng this request, please attach a copy o	of any document granting legal authority and complete the	